



CENTRON SECURITY SERVICES

Daily Security Report

Client No. 2036		Client Name O.H. METALS				Location OSWEGO, ST. UTICA, N.Y.				Date 12/7/86		
Facility Equipment NA	Detex Clock NA	Weapon No. NA	Holster NA	Nightstick NA	Raincoat 1	Flashlight 1	Other					
Officers: Fully explain all items marked "Yes" with time and all detail. For additional space use reverse side and attach incident reports.		Officer—Day Shift (Name) R. Felix				Officer—Swing Shift (Name) ofc Del Vecchio				Officer—Grave Shift (Name) R. Kokoszki		
Shift		Began		Ended		Shift		Began		Ended		
		8 AM		4 PM				12 PM		8 PM		
Observations or actions taken	Yes	No	Explanation		Yes	No	Explanation		Yes	No	Explanation	
Rounds or stations missed		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
Unlocked doors, gates or windows		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
Unlocked vaults or safes		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
Fire-smoke-or hazards		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
1. Extinguishers missing or defective		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
2. Sprinkler system defective		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
3. Fire doors or exits blocked		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
4. Rubbish accumulation		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
5. Motors running		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
6. Lights left burning		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
Injury hazards		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
Visitors		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
Trespassing		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
Violation of company rules		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
Remarks MADE VISUAL CK. OF BLDG. PERIMETER EVERY HR. (R.K.) made visual check of Bldg. & premises - every hour (R.K.) made visual check every hour, hole in fence on Oswego St. (R.K.)												
IMPORTANT: If you were ill or injured please explain on the reverse side of this form and call your supervisor before leaving this post.												
1. Were you injured during this tour?	Day Shift	1.	2.	3.	Swing Shift	1.	2.	3.	Grave Shift	1.	2.	3.
	Yes	<input checked="" type="checkbox"/> No	Yes	No	Yes	No	Yes	No	Yes	<input checked="" type="checkbox"/> No	Yes	No
2. Did you suffer any illness?	Yes	<input checked="" type="checkbox"/> No	Yes	No	Yes	No	Yes	No	Yes	<input checked="" type="checkbox"/> No	Yes	No
3. Have you reported all accidents coming to your attention?	Yes	<input checked="" type="checkbox"/> No	Yes	No	Yes	No	Yes	No	Yes	<input checked="" type="checkbox"/> No	Yes	No
Signatures	Day Shift	Renneth Felix			Swing Shift	ofc Del Vecchio			Grave Shift	R. Kokoszki		
Signatures	2.				2.				2.			
Signatures	3.				3.				3.			

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